Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: Southeast Health Services P O BOX 453062 Garland, TX 75045	MFDR Tracking #: M4-04-7158-01 DWC Claim #: Injured Employ
Respondent Name and Box #: Dallas County Rep Box # 42	Date of Injury: Employer Name Insurance Carrie

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: Per the Table of Disputed Services "Denied as 'not documented', however, the charges incurred are clearly documented and was billed for the patient's first visit with her physical therapist…Claim sent in two times via mail with no response from carrier regarding payment or denial."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - $690.00
3. CMS 1500(s)
4. EOB(s) (6-4-03 and 6-24-03 dates of service only submitted)

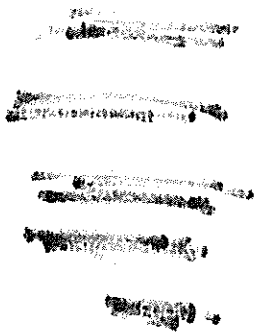
PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: No position summary submitted

Principle Documentation: 1. Response to DWC 60
2. EOB(s) (6-9-03 date of service)

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Code(s) and Calculations	Denial Code(s)	Part V Reference	Amount Ordered
06-04-03	95834 95851	N17 N17	1 & 2 1 & 2	$00.00 $00.00
06-09-03	97110 (4 units) 97035 97139 97016 99213-MP	N72/D91 N72/D91 N72/D91 N72/D91 N72/D91	1 - 3	$00.00 $00.00 $00.00 $00.00 $00.00
06-24-03	99213-MP	N11	1 & 2	$00.00
06-27-03	97110 (4 units) 97035 97139 97016	NO EOB	4	$00.00 $00.00 $00.00 $00.00
Total Due				$00.00



PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Section §413.011(a-d) titled, *Reimbursement Policies and Guidelines*, and the *1996 Medical Fee Guideline*, effective April 1, 1996, sets out the reimbursement guidelines.

1. These services were denied by the Respondent with denial codes:
   - N17 - Not appropriate documented. Upon review, documentation submitted did not contain information specific to this service.
   - N72 - Not appropriate documented. Documentation must include treatment provided (with days of week), response to treatment, progressive overall improvement of symptoms; failure to respond to treatments).
   - D91 - Duplicate bill. This appears to be a duplicate charge.
   - N11 - Not appropriate documented. Upon review, documentation as submitted does not support the level or service(s) billed. Reimbursement based on level of service documented.

2. Per Rule 133.307(g)(3)(A-F) the Requestor submitted documentation for review. The documentation submitted does not support the service(s) billed. Specifically, the Requestor billed with modifier MP for date of service 06-24-03. The documentation does not document a manipulation being performed. No reimbursement is recommended.

3. This is not a duplicate bill, however, a second submission of the same bill to the Respondent for reconsideration. The Requestor submitted documentation for review, however, the documentation does not include the response to treatment and the overall improvement of symptoms, but simply states "continue with treatment plan." The documentation does not support the services billed. No reimbursement recommended.

4. Neither party submitted a copy of an EOB. Per Rule 133.307(e)(2)(B) the Requestor did not submit convincing evidence of a request for an EOB. This service is not eligible for review.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code Sec. §134.1 and §133.307
Subchapter G, Chapter 2001, Texas Government Code

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, section §413.031, the Division has determined that the Requestor is not entitled to reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature | Medical Fee Dispute Resolution Officer | 01-23-08 Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.